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HEALTH SYSTEM

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*HSHS is sponsored by Hospital Sisters Ministries and the Hospital Sisters of St. Francis is the founding Institute.*

January 26, 2015

Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

**Re: Bipartisan Chronic Care Working Group Policy Options Document**

Dear Committee Members,

Hospital Sisters Health System (HSHS) appreciates the opportunity to comment on the policy options outlined by the Bipartisan Chronic Care Working Group in the Policy Options Document released on December 18.

HSHS is a highly integrated, multi-institutional healthcare system of 13 hospitals and numerous physician practices in Illinois and Wisconsin. HSHS serves rural and midsized communities throughout both states and is committed to delivering high quality, compassionate, holistic, and cost-effective healthcare services to all. HSHS is sponsored by Hospital Sisters Ministries and Hospital Sisters of St. Francis, an international congregation dedicated to carrying forward the healing mission of Christ in the tradition of St. Francis and St. Clare of Assisi, is the founding institution. With revenues of $2.2 billion, our work is carried out by 14,000 colleagues and distinguished by substantial community benefits, with a special emphasis on the poor and vulnerable.

Effective care integration is essential for HSHS and CMS to reach our shared goals of improved population health, better patient experience, and reduced costs. Recognizing this national imperative for less costly and higher quality care, HSHS has been pursuing a Care Integration strategy since 2008. This strategy includes:

- *Physician Practices.* The HSHS Medical Group includes 370 physicians and midlevel providers in 93 health centers located throughout downstate Illinois and portions of Wisconsin. Prevea is a multispecialty group of 340 physicians and midlevel providers in a partnership arrangement with four HSHS hospitals in Northeastern Wisconsin. Prairie Cardiovascular Consultants, Ltd. (PCCL), based in Springfield, Illinois and owned by HSHS, is the largest single specialty cardiology group practice in Illinois and Missouri. PCCL has developed a nationally recognized specialty heart and vascular care system by partnering with rural communities throughout central and southern Illinois, with 49 clinic sites across 45 counties.

- *Physician Clinical Integration Network, LLC (PCIN).* PCIN includes the above medical groups, along with over 900 independent physicians in parts of Wisconsin and throughout central and southern Illinois. Governed by an all-physician board, PCIN allows both employed and independent physicians to work together to improve quality and reduce cost in a shared savings model.

- *Care Coordination Innovations.* As part of our effort to improve care coordination capabilities, we implemented a patient-centered medical home (PCMH) model in 15 Illinois sites and at Prevea Health, our Wisconsin-based medical group partner. Most of the sites are in rural areas.

- *Private Label – Shared Risk Pool.* In partnership with Dean Health Plan, HSHS has a private label, shared risk plan, Prevea360, operating in Eastern Wisconsin. The plan is in its second year of operation, has over 10,000 members, and is exceeding financial projections. Hospitals and physicians share equally in gains and losses.

HSHS applauds the Senate Finance Committee's efforts to improve care for Medicare patients with chronic conditions by establishing a bipartisan working group to look at this issue. We are pleased to respond to the Chronic Care Working Group's request for feedback on policies which could improve care coordination for this complex set of Medicare patients.

## Receiving High Quality Care in the Home

### *Independence at Home Demonstration*

HSHS strongly agrees with the Chronic Care Working Group's consideration to expand the current Independence at Home Demonstration. If the demonstration is expanded, HSHS agrees with the committee's proposal to modify the program to use hierarchical condition categories (HCC) risk scores as a way to identify complex chronic care beneficiaries for inclusion in the program. As currently structured, the program bases determination of beneficiary inclusion in the program on whether the individual has undergone a non-elective hospitalization within the last 12 months.

In addition, HSHS supports the Working Group's evaluation of the Centers for Medicare & Medicaid Services (CMS)-HCC Model and encourages the Working Group to consider models such as the disease specific models used by Aperivta or general health risk models with C-stats above 0.8. Another alternative would be convening an expert panel to provide recommendations on the best selection of risk modeling since the CMS-HCC Model only captures about 12 percent of patient risk.[1]

### *Expanding Access to Home Hemodialysis Therapy*

HSHS supports the Chronic Care Working Group's consideration to expand Medicare's qualified originating site definition to include free-standing renal dialysis facilities located in any geographic area. By expanding the originating site definition, Medicare beneficiaries who receive dialysis therapy at home would have the option to go to a freestanding renal dialysis

[1] Pope, Gregory C., et al. Evaluation of the CMS-HCC Risk Adjustment Model. RTI International, March 2011. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/evaluation_risk_adj_model_2011.pdf

facility to have their monthly visit with their clinician via telehealth without geographic restriction. In addition, beneficiaries would still have the option to have an in-person monthly visit with their clinician.

In addition, we believe that the home should also be considered an originating site for this limited purpose. We do not believe that any additional safeguards need to be in place for beneficiaries who are undergoing home dialysis therapy and who would be utilizing their expanded access to monthly visits via telehealth.

## Advancing Team Based Care

### *Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries*

HSHS supports the Working Group's focus on developing policies that improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. In addition to recommending that the Government Accountability Office (GAO) conduct a study on the current status of the integration of behavioral health and primary care among Accountable Care Organizations (ACOs) and medical homes, we would also encourage the Working Group to look at the impact that expanded use of tele-behavioral health tools have on improving care and outcomes for such patients.

## Expanding Innovation and Technology

### *Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees*

HSHS supports the efforts of the Working Group in evaluating how to provide MA plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual enrollees. As part of these efforts, HSHS believes that a per member, per month additive payment (PMPM) should be offered to plans that provide daily, intensive monitoring and treatment, including telehealth and hospital at home services designed to extend the level of care to members with chronic conditions over the course of 3-4 months. HSHS Hospital at Home services include intensive tele-monitoring including Bluetooth medical grade pulse oximetry, ECG telemetry, spirometry, weight and blood pressure measurement, and virtual camera-based assessment (visit http://www.hospitalathome.org for more information). HSHS believes that plans providing this level of benefit should receive a PMPM payment of at least $100 to help offset the investment and cost of care. We also recommend that only MA pans with a 4.5 or 5-star rating be eligible for this flexibility.

In addition, we recommend that the Working Group allow MA plans to make adjustments to provider networks to allow for a greater inclusion of providers and non-clinical professionals in treating the chronic condition or preventing the progression of the chronic disease. Specifically, we encourage the Working Group to allow MA plans additional flexibility to expand provider networks to include additional rural health providers.

Finally, we recommend that these flexibilities be granted to eligible MA plans who are focused on reducing the occurrence of high-cost admissions and readmissions as a result of a chronic condition. Likewise, we believe that, to maintain these benefit design flexibilities, MA plans would need to demonstrate a decrease in total costs for the plan.

### *Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees*

HSHS strongly applauds the Working Group's consideration to allow MA plans to offer a wider array of supplemental benefits than they do today. In addition to the supplemental benefits offered currently, HSHS recommends broadening these benefits to include: the delivery of nutrient dense food to patients living in "food deserts," counseling and social services, health coaching, use of remote access technologies, and transportation to appointments.

In our experience, these additional services improve the overall health of patients with chronic conditions, and by adding them to the list of supplemental benefits that can be offered by an MA plan, the number of individuals able to access these benefits would increase dramatically.

### Increasing Convenience for Medicare Advantage Enrollees through Telehealth

HSHS supports the Chronic Care Working Group's consideration of this policy option to permit MA plans to include certain telehealth services in their annual bid amounts. We strongly believe that MA plans should be permitted to include telehealth services in their annual bid amounts. Specifically, we believe that beneficiaries should have access to telehealth services from their home, especially given the range of studies that have demonstrated the effectiveness of these tools in improving outcomes while reducing costs. For example, for more than a decade, cardiologists at HSHS have demonstrated that the use of tele-monitoring devices in the home for patients with congestive heart failure reduces readmissions and the number of emergency room visits.[2]

### *Providing ACOs the Ability to Expand Use of Telehealth*

HSHS supports the Chronic Care Working Group's consideration to modify the requirements for reimbursement for telehealth services provided by ACOs in the Medicare Shared Savings Program (MSSP). However, we believe that all MSSP ACOs, regardless of the risk-track they are participating in, should receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services.

We agree for the need to establish sufficient safeguards as part of this process. As such, we would recommend that if the originating site requirement is lifted entirely or if additional originating sites, such as the beneficiary's home, are added, only clinical equipment from vendors who have approval from the Food and Drug Administration and who are Health Insurance Portability and Accountability Act compliant be used.

### *Maintaining ACO Flexibility to Provide Supplemental Services*

We agree with the need to clarify that ACOs participating in MSSP may furnish a social service or transportation service for which payment is not made under fee-for-service Medicare. In addition, we also agree with the need to clarify that ACOs participating in MSSP may furnish a remote patient monitoring service for which payment is not made under fee-for-service Medicare. We agree that making these clarifications would enable ACOs to spend their own

[2] Hos*pital Sisters Health System*. Case Study: Transforming Health Care Delivery through Care Integration. April 2013. Available at: https://www.hshs.org/WorkArea/DownloadAsset.aspx?id=21474836570.

resources on a broader range of services and capabilities to best serve their patient population. However, we urge the Working Group to evaluate the impact that these supplemental services have on patient care and total costs of care and use ACO experience in this area to consider expanding Medicare reimbursement to cover these services.

### *Expanding Use of Telehealth for Individuals with Stroke*

HSHS serves patients in both rural and urban areas and, as such, we have a great deal of experience in identifying and diagnosing strokes across a range of geographies and are acutely aware of the different reimbursement options available depending on location. In our experience, telehealth is a highly effective tool that can be used to facilitate the diagnosis of stroke and can help prevent the debilitating effects associated with delayed treatment. As such, we strongly support the Working Group's proposal to consider eliminating the originating site geographic restriction for the purpose of promptly identifying and diagnosing strokes, thereby allowing individuals in urban areas to opportunity to receive this form of care delivery as well.

## **Identifying the Chronically Ill Population and Ways to Improve Quality**

### *Ensuring Accurate Payment for Chronically Ill Individuals*

HSHS agrees with the need to conduct a study to examine whether the use of functional status, as measured by activities of daily living or by other means, would improve the accuracy of risk-adjustment payments.

In addition, we support the Working Group's effort to improve the CMS-HCC Model. We believe that the model should factor in social determinants of health, such as adequate nutrition, access to transportation, and family support. In addition, we recommend that the Working Group evaluate private efforts around predictive modeling and analytics, such as Apervita, Inc., in order to glean best practices and improve the predictive ability of the CMS-HCC Model.

### *Developing Quality Measures for Chronic Conditions*

HSHS agrees with the need to require CMS to include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. In addition, we agree with the need to require the Secretary of Health and Human Services to address how measures used by private payers and integrated delivery systems could be incorporated in Medicare; describe how coordination, to the extent possible, will occur across organizations developing such measures; and take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures. We believe that priority be given to outcome measures; patient experience measures; shared decision-making, including measures of patient engagement; and care coordination measures, including quality of life surveys.

We agree with the need for GAO to conduct a study on community-level measures as they relate to chronic care management and would be happy to work with GAO to provide a small market and rural perspective to the report.

## **Empowering Individuals & Caregivers in Care Delivery**

### *Encouraging Beneficiary Use of Chronic Care Management Services*

HSHS strongly supports the Chronic Care Working Group's proposal to considering waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high-severity chronic care code. We agree that waiving cost sharing requirements would incentivize beneficiaries to receive these services.

If the $8 copay continues, however, we strongly encourage CMS to play a more active role in educating beneficiaries about the chronic care management code by sending letters or mandating plans to send letters to beneficiaries receiving such services about the benefits of CCM.

***Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness***

As the Working Group notes, currently there is no specific payment code for a one-time visit to discuss issues associated with a diagnosis of a serious or life-threatening illness, such as Alzheimer's or Dementia. HSHS agrees with the proposal by the Working Group to consider requiring CMS to establish a one-time payment to clinicians to cover the cost of having conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness, such as Alzheimer's or Dementia. The purpose of this initial visit would be to discuss the progression of the disease, treatment options, and availability of other resources that could reduce the patient's health risks and promote self-management.

***Eliminating Barriers to Care Coordination under Accountable Care Organizations***

HSHS agrees with the potential to improve care of patients with chronic conditions by allowing ACOs in two-sided risk models to waive beneficiary cost sharing, such as co-payments, for items/services that treat a chronic condition or prevent the progression of a chronic disease. We believe that all beneficiaries in ACOs would benefit from the elimination of such cost sharing requirements, and so encourage the Working Group to consider extending this flexibility to Track 1 MSSP ACOs as well.

***Expanding Access to Prediabetes Education***

HSHS applauds the Chronic Care Working Group's consideration to recommend that Medicare Part B provide payment for evidence-based, lifestyle interventions that help people with prediabetes reduce their risk of developing diabetes. We believe that under Part B, all pre-hypertension, pre-diabetes, and pre-obesity self-management trainings should be reimbursed when delivered to high-risk patients. In addition, we support the development of stronger predictive models to identify high-risk patients and allow providers to conduct early interventions, treatment, and counseling to prevent disease progression.

***Expanding Access to Digital Coaching***

HSHS agrees with the need to have CMS to provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and help them in the self-management of their own health. As part of these efforts, HSHS recommends that CMS' website include information regarding the benefits of the chronic care management code and provide an explanation of the covered telehealth services.

**CONCLUSION**

HSHS thanks CMS for the opportunity to comment on the Chronic Care Working Group's Policy Options Document. We urge the Working Group to continue to consider the role of non-academic, rural health facilities in improving the care of beneficiaries and ensure that new payment and delivery models are structured to encourage participation by the full range of providers delivering care across the country. As such, we highly encourage the Working Group to evaluate some of the findings and research conducted as part of the Eugene Washington PCORI Engagement Awards, which specifically aim to bring in a broader range of nontraditional stakeholders into the healthcare research process.

If you have any questions about the recommendations outlined in this letter or would like to discuss them any further, please contact me at (309) 550-4711 or andrew.bland@hshs.org.

Sincerely,

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Chief Quality Officer
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